Project Concern International

Annual Report – Year 1

NCHE – Nutrition, Community and child health, and HIV / AIDS Education Project

Nchelenge District, Zambia

October 1, 2002 to September 30, 2007

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ACRONYMS

ADRA	Adventist Development and Relief Association
ANC	Antenatal Care
ARV	Anti-retrovirals
BCC	Behavior Change Communication
BPG	Breastfeeding Promotion Group
CBGMP	Community Based GMP
CBA	Community Based Agent
CBOH	Central Board of Health
CCE	Clinical Care Expert
CCLLR	Cross Cutting Lower Level Result
CDD	Control of Diarrheal Diseases
CHW	Community Health Worker
C/IMCI	Community Integrated Management of Childhood Illness
CO	Clinical Officer
CORE	The Child Survival Collaborations and Resources Group
CS	Child Survival
CSHGP	Child Survival and Health Grants Program
DDH	District Director of Health
DHMT	District Health Management Team
DIP	Detailed Implementation Plan
DTF	District Task Force
EHT	Environmental Health Technician
EN	Enrolled Nurse
FGD	Focus Group Discussion
FST	Field Support Team
GLT	Global Leadership Team
FP	Family Planning
GMP	Growth Monitoring and Promotion
HFA	Health Facility Assessment
HIO	Health Information Officer
HIS	Health Information System
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome
HR	Human Resources
I/C	In-Charges (at RHCs)
IEC	Information, Education, Communication
IO	International Office
KPC	Knowledge, Practice and Coverage
LINKAGES	Breastfeeding, Complementary Feeding and Maternal Nutrition Program
LLR	Lower Level Result
LOP	Life of Project
MA	Manager Administration
M&E	Monitoring and Evaluation
MCA	Malaria Control Agent
MCHN	Maternal and Child Health and Nutrition
MOH	Ministry of Health
MP	Manager of Planning and Development

MSF-H	Medecins sans Frontieres, Holland
NAC	National HIV/AIDS/STD/TB Council
NCHE	Nutrition, Child and community Health and HIV/AIDS Education
NDP	Ndola Demonstration Project
NE	Nutrition Expert
NFNC	National Food and Nutrition Commission
NGO	Nongovernmental Organization
NHC	Neighborhood Health Committees
NZP+	Network of Zambian Positive People
OR	Operations Research
OVC	Orphans and Vulnerable Children
PA	Program Advisor
PAC	Post Abortion Care
PCI	Project Concern International
PLA	Participatory Learning for Action
PLWA	People Living with HIV/AIDS
PM	Project Manager
PMTCT	Prevention of Mother-To-Child Transmission of HIV
PNC	Postnatal Care
PSI/SFH	Population Services International/Society for Family Health
PVO	Private Voluntary Organization
QIVC	Quality Improvement Verification Checklist
RBM	Roll Back Malaria
RDO	Regional Desk Officer
RHC	Rural Health Center
ROSA	Rapid Organizational Self Assessment
SHIHM	Stakeholders in Health Meeting
STI	Sexually Transmitted Infection
TBA	Traditional Birth Attendant
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
VCT	Voluntary Counseling and Testing
ZAMSIF	Zambia Social Investment Fund
ZIHP	Zambia Integrated Health Project

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I. Main Accomplishments

PCI and core partners gathered together on October 1, 2003 for the "NCHE: Year 1 in Review" meeting. Attendees listed main accomplishments, rated progress toward objectives, noted constraints and actions taken to address them in Year 1, and discussed the workplan and areas of technical assistance needed for Year 2.

The NCHE team and core partners are proud to list the following main accomplishments:

- Conducted:
  - Organizational capacity assessments – conducted ROSA with DHMT; re-evaluated recent assessments of PCI and DTF
  - Health facility assessments – adapted tools and assessed 10 rural health centers (RHC)
  - Knowledge, Practice and Coverage (KPC) Survey – adapted, translated, and pre-tested tool, adapted training materials, trained interviewers and supervisors, randomly sampled areas of the district and conducted survey
  - Focus group discussions (FGDs) to gather additional KPC data – designed and pre-tested discussion guide and conducted two discussions in rural areas and two in urban areas
  - DIP workshop, enabling partners to present and analyze key results from KPC, HFA, and capacity assessments, prioritize results, and develop action plans
- Hired full staff complement – with assistance from HR manager and Country Director in Lusaka
- Negotiated two staff secondments (part-time) from DHMT to NCHE
- Wrote DIP and presented it to USAID – with assistance from Country Director and International Office (IO) team
- Trainings for staff and partners - qualitative research, Epi-Info, and attendance at mini-university
- Discussed KPC results with RHC staff – during DHMT's quarterly meeting of RHC staff
- Inventoried outreach points and revitalized several – with DHMT; the beginning of the larger NHC revitalization component to be undertaken with ZIHP starting in November, 2003
- Procured vehicle – with assistance from IO team and USAID
- Instituted "Stakeholders in Health" group for district and coordinated monthly meetings – cited by attendees as an important coordinating mechanism, these meetings foster discussion among organizations who usually work toward the same goals, but independently. Participants are beginning to see the aggregated value in collaboration.
- Began training program; trained five community counselors for VCT – sponsored attendees at MSF-organized training. These community counselors will assist with pre-test counseling efforts in PCI's four RHC catchment areas (see Section IV of this report).

- Reinstated clinical reviews – During DIP workshop, DHMT cited desire to review a few select cases with health staff throughout the district on a regular basis; these are now taking place with efforts underway to formalize scheduling and enable wider participation through radio transmissions.
- Provided project information regularly to government-led District Development Coordinating Committee
- Designed project monitoring system and began monitoring – project team designed and tested a quarterly report format (see Annex A)
- Began PMTCT groundwork at four RHCs – Also see Section IV of this report. Groundwork includes site assessments using a tool adapted from national guidelines; communication and advocacy at national and provincial levels to link to the rolling out of the national PMTCT program (especially regarding standardized training and essential supplies); coordination with two hospital laboratories; negotiation with MSF-H program regarding areas of collaboration; sponsorship for training of RHC staff and VCT counselors; assistance to DHMT with design of monitoring plan for service delivery; coordination of supplies and logistics; planning PMTCT FGDs with NHCs.
- Assisted same RHCs with designating and equipping counseling space
- Identified existing Neighborhood Health Committees and assessed where additional NHCs are needed – NCHE staff began attending meetings and identified need for short-wave radios to link to national NHC education program during planned "Health Chats" between RHC staff and NHCs.
- Acquired many new technical materials to build a resource center for PCI and partners – PCI also designated office space for the resource center.

"The coming of the NCHE project has in a way contributed to the resource base in Nchelenge district. The money we save allows us to spend more on the health services."
--Health Information Officer, DHMT

(picture)

" We are…learning from the activities of the NCHE Project." --Environmental Health Officer, DHMT

(picture)

"As DTF, the overlapping issue is PMTCT. This is a staple of HIV/AIDS in Nchelenge. By the end of the day I am sure the project will make a very, very great impact." -- Department of Social Welfare representative, DTF Chairperson

The same group identified the following contributing factors to the accomplishments listed above:

- Commitment from partners
- Financial resources
- Supportive work environment (technical, human, material)
- Professional expertise of all partners
- Community contributions

In addition, this group notes that the project is doing the following especially well:

- Ongoing Stakeholders in Health Meetings (SHIHM)
- Establishing and maintaining strong partnerships
- Strong collaboration with DHMT
- Reviewing and implementing DIP
- In-house capacity strengthening
- Strengthening and establishing outreach points
- Capacity-building at all levels
- Financial accounting

The following table marks progress made toward objectives (results) at the end of Year 1 and includes activities earmarked for Year 1 in the DIP.

Results	**Progress**
LLR1.1: Increased availability of MCHN services	Yes
• Decentralize VCT	Yes
• Procure and deliver drugs, vaccines and supplies/equipment	Yes
• Proposals to Zamsif for RHC staff housing	Yes
• Procure equipment and supplies for PAC *(See Section II of this report)*	No
LLR1.2: Enhanced quality of MCHN services	Yes
• Create and implement maintenance schedule for equipment	Yes
• Reinstate clinical reviews	Yes
LLR1.3: Improved advocacy and coordination of MCHN services	Yes
LLR2.1: Increased demand for and utilization of MCHN services	Yes
LLR2.2: Increased access to MCHN services	Yes
• Acquire, adapt and distribute IEC materials to RHCs	Yes
• Expand coverage of Chlorin with Society for Family Health	Yes
LLR2.3: Improved knowledge of prevention and care-giving practices and improved care-seeking behaviors	Yes
• Educate RHC staff regarding community behaviors and encourage promotion of messages using small and mass media	Yes
• Conduct further research on care-seeking behaviors (doer/non-doer analysis)	Yes
CCLLR1: Improved integration and coordination within formal health sector and between formal health sector and community	Yes
CCLLR2: Enhanced organizational development and capacity of DHMT, DTF, and PCI	Yes
We share widely and discuss evaluation findings with network members • DTF quarterly meetings • Attend intersectoral meetings (DHMT)	Yes
We engage in systematic, regularly-scheduled self-assessments of organizational capacity • Conduct performance assessments (DHMT) • Review workplans (DHMT)	Yes
Problem solving and decision-making are done collaboratively between line staff and supervisors • Hold inter- and multi-sectoral meetings • Train NHCs, RHC, DHMT, CHWs • Hold technical meetings	Yes
Client needs and opinions are considered to be important dimensions of quality • Advocate for rights of clients and educate RHC staff and clients as to clients' rights • Counseling (improve data collection)	Yes

We work to de-stigmatize HIV/AIDS • Decentralize VCT • Revamp anti-AIDS clubs • Procure IEC materials • Train health workers • Strengthen monitoring of counseling	Yes
We address nutritional needs of PLWAs • Adapt existing manuals to Nchelenge context *(See Section III of this report)*	No
Service delivery protocols are updated/revised regularly • Review existing protocols	Yes
CCLLR3: Improved sustainability of MCHN services	Yes

II. Overcoming Constraints

The following is a list of constraints encountered and the measures taken to address them:

- Vehicle: NCHE could not get authorization to purchase the vehicle needed (Toyota) until March. With assistance from the logistics team in Lusaka, NCHE hired a vehicle for the interim. With assistance from IO, NCHE continuously advocated USAID for the procurement waiver and purchased the Toyota in April.
- Electricity: The power supply in Nchelenge is erratic. PCI and partners showed great flexibility in working through this. Efforts included working by candlelight, shifting schedules, and traveling to the provincial capital (2.5 hours) to photocopy the KPC survey. NCHE also purchased a small generator, which helps with computer use, but it cannot power the photocopier.
- Understaffing: NCHE came to full staff in September. Until May, the Project Manager, Program Advisor and support staff worked long hours with core partners to complete all assessments and reports. Consequently, the Project Manager, who also functions as the DTF Secretariat, could not spend the desired amount of time transitioning aspects of the Secretariat's role to the DTF Executive Committee. The transition is also complicated by the last point in this list—relocation of Executive Committee members.
- "Crashing programs" (conflicting schedules): Due to a lack of trained health staff in Nchelenge, the same qualified people serve on several committees and projects. NCHE staff and partners are flexible about changing meeting times and work schedules, sometimes at the last minute, while minimizing disruption to project implementation.
- Financial management: It was difficult for the Project Manager and Program Advisor to manage project accounting for the first five months of the project. Hiring the cashier, opening a local bank account, and establishing accounting procedures through a series of meetings with the finance team in Lusaka overcame that constraint, and now PCI and partners cite financial management as something NCHE does well.

- Ignorance of clients' rights: This was recognized as a constraint to achieving CCLLR2 (Standard: Client needs and opinions are considered to be important dimensions of quality) during the "Year in Review" meeting. Plans were made to research national and international standards and then to sensitize health providers and clients.
- Project is not yet ready to deal with certain specific issues (like Post-abortion care [PAC]): This also came out during the meeting. Recently coming to full staff and time itself will mitigate this constraint. As the project gains strength and becomes well-established, more and varied health issues can be addressed.
- PCI name-recognition in the community: staff of one partner commented that while some programs start with a "bang", it has taken PCI a long time to increase understanding of the NCHE project in the community. SHIHMs and full staffing are two ways that PCI is addressing this issue. PCI will also construct a large sign near the southern entrance to the district.
- Poor communication: Phone lines are unreliable in Nchelenge. PCI purchased a satellite phone, which is helping to overcome this constraint in emergencies. DHMT secured a donation of high-frequency radios for RHCs and the hospital. PCI is planning to purchase a satellite dish for internet use when the service becomes available in Zambia. Poor connections have led to substantial periods of time when project management is without email and internet access.
- DTF Executive Committee members relocated: After completing the DIP together, the DTF, one of NCHE's core partners lost three influential volunteers. Since then, PCI has been assisting the DTF with rebuilding the Executive Committee and orienting new members to NCHE. This has slowed progress for the DTF and for NCHE overall.

III. Technical Assistance for Year 2

PCI and partners identified the following areas of technical assistance potentially needed during Year 2:

- Materials adaptation and strengthening internal expertise in nutrition for PLWA
- PLA for NHC revitalization and to strengthen internal expertise
- Operations research for HIV/AIDS stigma reduction
- IEC materials design and adaptation
- Sustainability – NCHE applied to CSTS+ for assistance with its sustainability plan. PCI's Indonesia CS project was granted assistance in this area and NCHE will tap into that experience as much as possible to strengthen its plan.

IV. Changes to Project Description

There have not been substantial changes from the project description in the DIP**.** A significant change to implementation resulted when PCI and MSF-H met to clarify workplans. These organizations subsequently agreed that PCI and partners will continue

to strengthen activities supporting prongs 1 and 2 (preventing HIV infection in women and preventing unintended pregnancy) of the global strategy for PMTCT in all RHC catchment areas. MSF requested that PCI refrain from activities supporting PMTCT service provision and most care and support activities at the six RHCs where MSF is working. PCI and partners have agreed to focus efforts for these activities at the remaining four RHCs, although it is anticipated that further collaboration (with prongs 3 [PMTCT] and 4 [care and support]) at all RHCs may be needed in the coming months as the district unrolls PMTCT in line with provincial and national plans. PCI will offer all possible support in Nchelenge district as the national program unrolls.

Please refer to the *Quarterly Report, 4th Quarter* in Annex A 1 to view the project's quarterly monitoring plan. The format of the quarterly report is adjusted slightly each quarter to reflect the project's workplan. Annex A 2 reports annual measurements. Extensive assessments for Year 1 (organizational capacity, health facility, KPC) were baseline measures and those reports were included in the DIP.

V. Recommendations from DIP Review

USAID requested the following recommendations be addressed before DIP approval:

1. Indicators which reflect standard definitions and data source for each indicator.
2. Revise targets and/or provide sufficient information to justify maintaining targets.
3. Provide a brief explanation of how the issue of stock supplies will be addressed.

Revisions were made (please see the DIP, Section E3) and the DIP was approved. In addition, PCI continues advocacy efforts at all levels (district, provincial, national) to improve the supply stock. PCI has also recently linked with other organizations including LINKAGES, PSI/SFH, UNICEF, and ZIHP to access materials and supplies. MSF-H sources its supplies independently of the DHMT and will not donate or share supplies with the NCHE Project because it is required to monitor the distribution of its supplies and cannot donate outside of its service provision areas.

VI. Project Management Systems

Financial Management System: NCHE abides by USAID regulations for financial procedures and reporting requirements. The financial system also complies with PCI's worldwide requirements. The accounts team consists of the Finance Manager and Finance Assistant, both based in Lusaka, and the project Cashier, based in Nchelenge. The Project Manager or Program Advisor approve and authorize expenditures, and are signatories to the project bank account. The Project Manager signs all financial reports. Lynn Nelson, Finance Officer and Jenny Choi, Regional Desk Officer at IO ensure adequate and timely financial record-keeping and reporting.

The Project Manager and Program Advisor review and adjust the budget for each year according to the USAID approved project budget. The Cashier prepares the monthly financials and the Finance Team in Lusaka maintains the project records. These records are forwarded to the IO Financial Officer and Regional Desk Officer for review. The entire Financial Team monitors and tracks expenditures. PCI's procurement procedure also follows USAID policy.

Human Resources: In Zambia, the HR manager is based in Lusaka and she reports to the Country Director. NCHE is currently at full staff, with seven technical (two part-time seconded) and three administrative positions. Staff were recruited according to PCI's worldwide and local policies. NCHE staff report to the Project Manager; the Manager and Program Advisor report to the Country Director (see organization chart in Annex C). The Country Director reports to the Vice President for Operations at IO, who reports to the President. Also at IO, the Regional Desk Officer (RDO) backstops the program by ensuring grant compliance, maintaining clear and effective communication between the field office and the IO, monitoring and communicating about financial spending and managing the Field Support Team (FST) process. The FST meets quarterly and is comprised of at least one representative from each department at IO (see *Communication system and team development*). The Technical Officer for Maternal and Child Health provides quality assurance and technical assistance to the project.

Communication system and team development: Three levels of communication are described below: within project, between the project and country offices, and between Zambia and the IO.

Within project

Staff meet on a weekly basis to discuss progress. Staff also attend longer quarterly meetings to review the quarterly workplan, "unpack" big activities by breaking them into manageable steps, and review progress toward project objectives. Staff also divide sections of the quarterly report at this meeting and agree on a timeline for completing the report. The Program Advisor maintains a small office in the provincial capital where she liaises with provincial health supervisors. She visits the project on average twice each month for three days each time, and communicates with project staff by phone and fax several times each week.

Partner staff are integrated with project staff, by virtue of PCI's innovative secondment arrangement, whereby two DHMT staff (MCH Specialist and Nutritionist) spend the equivalent of one day each week with the NCHE Project directly. The arrangement is integrated through the daily efforts of these two staff who work toward project objectives and liaise between PCI and the DHMT through the course of their daily work with the DHMT. Another integrated aspect of staffing is that the NCHE Project Manager maintains his position as the DTF Secretariat, and through monthly meetings with the DTF Executive Committee and quarterly meetings with the general membership, continues to liaise with the DTF as a NCHE Project core partner, and facilitate its planning of activities to achieve project objectives.

Between Project and Country Office

The NCHE project office communicates with the Lusaka (main) office a few times each week by phone and fax. The NCHE office does not have email capability and phone lines are poorly maintained by the national communication company, challenging communication on a regular basis. The Program Advisor is able to communicate more frequently with the Lusaka office through email, and often acts as a conduit for information between Lusaka and Nchelenge. In addition, project staff try to visit Lusaka every six weeks on average to maintain organizational communication, procure supplies, and continue advocacy and partnership efforts with the central government and Lusaka-based NGOs and donors, including the USAID Mission.

Between Zambia and the IO

The Country Office communicates with the IO through several means. These include monthly reports, monthly financial reports and quarterly FST meetings. The NCHE Project submits quarterly progress reports to the Lusaka office, IO, and the USAID Mission. The Program Advisor coordinates with the RDO, MCH Technical Officer and the VP Technical Services regarding technical assistance needs and program development opportunities. The FST involves representatives from each department of the IO: Program, Resource Development, Finance, Information Technology and HR/Organizational Development with the Country Director often participating via conference call. The agenda includes an in-depth look at every facet of the program including: program and technical quality, financial management, resource development, administration and communication. Each area is monitored through the use of a "stop light" process assigning a "green" when functions are operating smoothly, a "yellow" if some problems or potential problems exist or additional information is needed, and a "red" for any crisis that may place the program in jeopardy. In the event of a red light, action must be taken within 7-14 days. The RDO is responsible for managing this process and ensuring follow-up to action items prior to the next FST meeting.

PCI worldwide issues are discussed during bi-annual Global Leadership Team (GLT) meetings, which include all of PCI's Country Directors as well as the IO Leadership Team. The GLT is involved in strategic planning decision-making, organizational restructuring, budget approval and program expansion. Daily needs and updates are relayed to the IO through e-mail. There are also informal communications via phone calls to clarify or resolve urgent issues.

Local partner relationships: NCHE Project's core partners are intimately involved with project implementation. As mentioned in Section I, core partners attended a "Year 1 Review" meeting, and contributed directly to the content of this report. See also "Within Project" communication, described above.

NCHE hosts a monthly "Stakeholders in Health Meeting" (SHIHM). Invitations are sent to all NGOs, the DHMT, the hospital, and community organizations whose activities impact health. Since November, this has functioned as a coordinating mechanism for health activities in the district. In addition, these meetings build collegiality and foster

cooperation among the attendees and reduce competition between organizations. The net result is a greater positive impact on health district-wide.

During visits to Lusaka and through email when possible, NCHE staff update NGOs and government regarding project progress, with the aim of coordinating efforts when possible. NCHE Project maintains communication with the USAID Mission, LINKAGES, ZIHP, UNICEF, PSI/SFH, and CBOH on a regular basis. As a result, NCHE has obtained references and/or training and IEC materials from all of these organizations and institutions.

PVO coordination/collaboration in country: NCHE staff joined the Roll Back Malaria coordinating committee, chaired by World Vision. Recently, PCI joined with World Vision and ADRA to submit a proposal to the CORE Group to host a case study workshop in Zambia.

Other management systems: N/A

Organizational capacity assessment: PCI conducted a self-assessment of organizational capacity in October 2001 (not during LOP), which is described in detail in the DIP. PCI undergoes an A-133 organization-wide audit each year and received one unqualified opinion and one management letter finding from its most recent audit; PCI is implementing corrective actions to address this finding.

VII. Year 2 Workplan

Please see Annex B. A detailed workplan and "unpacked task table" for the first quarter are also included, as they contain activities from Year 1 carrying over into Year 2.

VIII. Key Issue Highlighted

Note: The following was submitted to Tom Hall, USAID on September 5, 2003.

Project Concern International Program Highlight: Integrating PMTCT with C-IMCI

In addition to addressing the traditional range of maternal and child health issues with community-based integrated management of childhood illness (C-IMCI), PCI is integrating the prevention of mother to child transmission of HIV/AIDS (PMTCT) with C-IMCI in the NCHE (Nutrition, Child and community, Health and HIV/AIDS Education) Project in Nchelenge District in northern Zambia, population about 130,000. Integration occurs under each of the three elements and with the multisectoral platform (see below), in partnership with the District Health Management Team (DHMT) and the District Task Force for HIV/AIDS (DTF). There is the potential, indeed the need, for scale-up of this comprehensive approach in places affected by HIV/AIDS. Since it is

widely believed that HIV/AIDS is turning back the gains made in child survival over past decades, it is expected that this integrated approach, by acknowledging and addressing maternal and child health (MCH) issues that are directly affected by HIV/AIDS, will hold firm progress made in child survival and continue to increase impact in places with high HIV/AIDS prevalence.

Element 1: Improving partnerships between health facilities and the communities they serve. PCI and partners are facilitating the training of rural health center (RHC) staff in PMTCT and C-IMCI, while making improvements to infrastructure where necessary (e.g. designating and equipping space for confidential counseling). PCI and partners are also acquiring and upgrading needed supplies for the range of reproductive health services in the RHCs. In conjunction with other efforts described in this document, PCI and partners are strengthening RHC links to communities through revitalized Neighborhood Health Committees (NHCs), improved access to IEC materials, enhanced RHC-supervision of community-based agents (CBAs) and introduction of quality assurance methods that incorporate client feedback. In addition, aggregate information regarding voluntary counseling and testing (VCT) services is provided to health workers and decision makers to improve understanding and learning about issues related to MTCT and how best to prevent it. Collectively, these efforts improve the impact of health service delivery (e.g. relative to traditional facility-based programs) by incorporating the feedback and soliciting the participation of those served.

Element 2: Increasing appropriate and accessible health care and information from community-based providers. PCI and partners are training new community health workers (CHW) and traditional birth attendants (TBA) and providing refresher training to existing CBAs in all areas of MCH, including PMTCT, while strengthening the supervisory system of CBAs from the RHCs. CBAs work to spread messages about HIV/AIDS risk reduction and supply condoms, encourage VCT, antenatal care, and delivery with a trained provider, support the optimization of mothers' infant feeding decisions, and refer clients to support groups and other programs (e.g. home-based care), as appropriate. In addition, CBAs play an important role in the reduction of HIV/AIDS stigma. PCI and partners are designing an operations research to assess the feasibility of community-based distribution of ARVs.

(picture)

Hundreds of mothers queue for growth monitoring outside of RHC. They brought sand to contribute to the construction of a new RHC.

Element 3: Integrating promotion of key family practices critical for child health and nutrition. PCI and partners are encouraging NHCs to support adoption of key household practices and to collect community health data. CBA efforts will also support critical behaviors at the household level. In addition to the key family practices identified by BASICS, PCI has included certain PMTCT-related practices among those it is seeking to improve in the project area. These include risk reduction (HIV/AIDS) behaviors, access to VCT services and peer support, adoption of a safe delivery plan, and optimal infant feeding practices. NCHE's anti-stigma efforts will also support positive behavior change at household and community levels.

Multisectoral Platform: *PCI's partner, the DTF, is a multisectoral network that mobilizes public and private partnerships to address HIV/AIDS issues in the district. The DTF, like the NHCs, is a key mobilizing force in the community, and brings the strengths of many sectors, public and private, to bear on health issues. Specific activities include community mobilization, IEC, OVC support, home-based care and VCT.*

(picture)

Mothers preparing for cooking demonstration, led by CHW.

Annex A-1

NCHE QUARTERLY REPORT

QUARTER: 4; Year 1

(Note: many indicators are not yet quantifiable as associated activities are just getting underway)

Strategic Objective: Improved health and nutrition of children <5 in Nchelenge District

LLR1.1: Increased availability of MCHN services

Indicator	Measurement Method and Frequency	Targets	This Quarter
% Facilities offering full range of services*	Observation/interview of facility, health post and outreach point staff, DHIS reports; quarterly *(randomly choose two to visit; review DHIS for others)*	100%	100%
% Community *outreach points* offering minimum service package (as determined by DHMT)**	(Same as above)	100%	Not measured
% Facilities and community services with adequate operation hours as defined by the community	(Same as above)	100%	Not measured

** Full range of services: Immunizations; curative (malaria, diarrhea, pneumonia, et al); preventive and promotive services (static and outreach); ANC, PNC, and safe deliveries; family planning; GMP/N*

*** Minimum service package: preventive and promotive services (GMP/N, malaria prevention and control; CDD; ARI)—DHMT needs more time to define this.*

Major Activities	Personnel[11]	Status*
Health Facility • Decentralize VCT (train counselors and integrate with RHC services)	PCI: VC, PA, TC; DHMT: MP, MA, CCE	Progress
District • Procure and deliver drugs, vaccines, supplies, and other equipment to RHCs • Open more health posts and create more outreach points	PCI: PM; DHMT: MA PCI: OCs, (see above)	Progress

Notes:

i. VCT Decentralization- started with PMTCT assessment of the four RHCs (Kabalenge, Kanyembo, Nchelenge & Kashikishi). This has been followed by a training of five Community-Counselors from the four catchment RHCs.

[11] For PCI, the CS Program Advisor (PA) and NCHE Project Manager (PM) will be involved to some extent in every activity; their initials are listed when substantial involvement is anticipated.

ii. Identified additional out reach points with RHC staff and NHCs' participation in all RHCs. Project to open up new outreach points to increase access for underserved populations within the district. Plan to start servicing them in year two.

LLR 1.2: Enhanced quality of MCHN service delivery

Indicator*	**Measurement Method and Frequency**	**Targets**	**This Quarter**
% Client satisfaction with MCHN services received from health providers at facilities	Client exit surveys; quarterly	90%	Not measured
% Client satisfaction with MCHN services received from community-based health providers	Client exit surveys; quarterly	90%	Not measured
% Service providers with increase in knowledge and skills related to MCHN services	Training pre and post-tests supervisory records; as they occur and quarterly	90%	Not measured
% RHC staff satisfied with supervisory system	Staff feedback given on supervising forms; quarterly	90%	Not measured

Major Activities	**Personnel**	**Status**
District • Create and implement maintenance schedule for equipment	DHMT: MA	Progress
• Reinstate clinical reviews	PCI: TC, PM; DHMT: MA, MP, CCE, Hosp MO	Progress

Notes:

i. Equipment maintenance schedules started with District Health Office and now extending to RHC inventory of equipment and develop/create schedule thereof.

ii. Clinical reviews started; done two centers, Kafutuma& Nchelenge. Hospital Medical Officer yet to be on team. So far, record keeping and general patient information coming out as issues that require attention. Plan to utilize "Peer" Clinical review meetings among RHC staff.

iii. Trained/reviewed use of partograph with staff at quarterly RHC meeting.

LLR 1.3: Improved advocacy and coordination of MCHN services

Indicator	**Measurement Method and Frequency**	**Targets**	**This Quarter**
% community-based providers that appropriately refer clients	Supervisor records; quarterly	80%	Not measured

No major activities in this quarter

LLR 2.1: Increased demand for and utilization of MCHN services

Not measured on a quarterly basis

No major activities this quarter

LLR 2.2: Increased access to MCHN services

See 1.1

Major Activities	Personnel	Status
District • Acquire, adapt and distribute health education materials to RHCs and outreach posts • Expand coverage of Chlorin social marketing campaign (with SFH) • See 1.1	 PCI: PA, TC; DHMT: all PCI: PM; DHMT: MP	 Progress Progress

Notes:
i. Contacted national and local partners to determine what health education materials are available.
ii. Chlorin sales and marketing is handled by Mansa office of SFH (PSI), as such; the Nchelenge outlet was not in a position to ably discuss with project staff on the matter. Project advisor began discussions with Mansa office.

LLR 2.3: Improved knowledge of prevention and care-giving practices and improved care-seeking behaviors

Not measured quarterly

Major Activities	Personnel	Status
Health Facility • Educate RHC staff regarding community behaviors and encourage them to promote messages using mass and small media	PCI: TC, VC; DHMT: MA, MP	Progress
District • Conduct further research on care-seeking behaviors (doer/non-doer analysis)* • Acquire, adapt and distribute health education materials to RHCs and outreach posts	PCI: PM, OCs; DHMT: all	Progress

**emphasis behaviors (C-IMCI) and any required by DHMT through DHIS*

Notes: RHC staff were sensitized on the emphasis behaviors during the second quarter RHC quarterly meeting. Advised to discuss with NHCs to select behaviors requiring further follow-up (Doer/Non-Doer Analysis) in the respective RHC catchment areas. PCI to follow up with behavior selection as part of NHC revitalization.

CCLLR 1: Improved integration and coordination within formal health sector and between formal health sector and community.

See LLR 1.3 for indicators and activities. Activities crosscut through the tables above.

Notes:
i. With the help of NHCs, identified 15 additional outreach points. Also, encouraged RHCs to have a schedule of NHCs'meetings to enable project /DHMT support to NHCs.
ii. Facilitated SHIHM, which linked national Red Cross to cholera control efforts.
iii. Staff will acquire short-wave radios for the RHCs so that NHCs can link to the nationally broadcasted program.

CCLLR 2: Enhanced organizational development and capacity of DHMT, DTF, and PCI

Not measured quarterly

Standard: We share widely and discuss evaluation findings with network members

Activity	Key People	Status
DTF		
Annual General Meeting	PCI Field coordinator. DTF Exec.	
Quarterly Meeting (Field Office) 1-Arrange meetings 2-Review previous annual work plans 3-Develop uniform reporting format 4-Discuss achievements & areas to improve 5-Discuss solutions 6-Draft annual work plans	All	Progress
DHMT		
Attend inter sectoral meeting (7 districts) -Prepare reports (district level, RHC level, community level)	DDH, MP, HIO	Progress

Standard: We engage in systematic, regularly scheduled self-assessments of organizational capacity

Activity	Key People	Status
DTF		
Qtrly & Annual Meetings 1-report on activities from institutions 2-Identify gaps 3-Identify solutions to gaps 4-Develop action plans	Exec. Committee (coordinate DTF activities	Progress

DHMT		
Performance Assessment/QA 1-Prepare PA tools 2-Distribute PA tools 3-Give specific feedback to HC 4-Give feedback to all facilities	DDH/MPD	Progress
Self Assessment 1-Distribute data collection tools 2-Collection of data & aggregation 3-Data validation 4-Data analysis 5-Feedback to specific indicators 6-Feedback to all facilities	MP	Progress
Action & work plan review 1-Prepare reports 2-Hold intersectoral mtgs	DDH/MPD	Progress

Notes:
DHMT convened planning meeting with all RHCs (included chairpersons from each NHC of the RHC catchment area). DHMT shared with RHCs, NHCs, partners in the district on new guidelines from CBOH, including the Indicative Planning Figure (IPF) for the coming year's budget. RHCs assigned to work with NHCs to come up with draft action plans that will be reviewed at a later meeting (with partners).

Standard: Problem solving and decision-making is done collaboratively between line staff and supervisors.

Activity	Key People	Status
DTF		
Holding inter-& multi-sectoral meetings/prgs 1-Identify institution w/ common interests	DTF membership Chairman	Progress
DHMT		
Monthly Meetings (CBHM, Technical) 1-prepare agenda 2-make appointments 3-select venue	MP	Progress
Support supervision	MP	Progress

Notes: DHMT convenes technical committee meetings (district health office and hospital) to facilitate dialogue. DHMT also convenes meetings of district health management staff at RHC quarterly meetings. The District Health Board meets quarterly.

Standard: Client needs and opinions are considered to be important dimensions of quality.

Activity	Key People	Status
DTF		
1-Conduct needs assessment 2-Advocate rights of client 3-Counseling (data) 4-Follow-up assessment mtgs 5-Coming up w/ basic questions during counseling	DTF/Chairman PCI Field Coordinator Roles: Advocacy Awareness Sensitization	No Progress
DHMT		
A-Exit survey interviews 1-prepare checklists 2-distribute to interviewers/supervisors 3-identify clients 4-feedback to service providers/community *B. Ensure counselor supervision.*	MP, I/Cs *DHMT*	No Progress Post poned to qrtr 2, y2. Progress

Notes: Counselor supervision tools reviewed and contacts made with institutions having counselors on how best this will be done.

Standard: We access and apply relevant technical information to program design work.

Activity	Key People	Status
DTF		
No quarterly activities		No progress
DHMT		
Training specific (PLA, Log/Results Framework) 1-Identify trainers/trainees 2-Module prep. 3-Arrange for trainings	MP, NE, HIO	No progress
Literature review 1-Procure available relevant literature	MP, CCE, HIO	Progress

Standard: We work to de-stigmatize HIV/AIDS.

Activity	Key People	Status
DTF		
Decentralize VCT 1-counseling 2-procure logistics (test kits)	DTF/chairman Role: to coordinate & mitigate	Progress
Revamp & Form new anti-AIDS clubs 1-community sensitization 2-recruit members 3-train & assign roles	Same as above; *MOE HIV focal person*	Progress
Form post-test clubs 1-community sensitization 2-recruit members 3-train & assign roles	Same as above	Progress
DHMT		
IEC/BCC 1-Procurement of IEC materials 2-distribute materials 3-train counselors & peer educators	CCE	Progress
Training of health workers See 3 a, b, c & d	MP	Progress
Monitoring 1-develop plan 2-tools	HIO	Progress

Notes: See LLR1.1; DTF inventoried existing anti-AIDS Clubs and PCI met with some NHCs. PCI will assist ZIHP with NHC revitalization beginning in November in Nchelenge District.

Standard: We address nutritional needs of PLWHAs.

Activity	Key People	Status
DTF		
No activities this quarter		
DHMT		
Adapt existing manuals to Zambian (Nchelenge) context 1-procure/acquire nutritional manuals on HIV/AIDS (Zimbabwe, FAO, & RSA) 2-hold technical meetings/workshop 3-manual development 4-demonstration contests 5-distribute adapted manuals	NE	No progress; Year 2, quarter one – to start addressing activity.
Monitoring harmonize w/ PSG, MSF 1-home-based care (visits) register 2-identify PLWHAs	CCE	Progress
Counseling in Nutrition (TIPS)	NE	Progress

Notes:
Discussions underway to harmonize HBC monitoring. Plan is for caregivers to train family members. Some caregivers want payment for services; NCHE is reviewing incentive plan for all community-based agents.

Standard: Service delivery protocols exist and are regularly revised and updated (DHMT only)

Activity	Key People	Status
Review existing protocols 1-check correctness & completeness 2-formulate tech. Committees 3-feedback- Qtrly mtgs 4-write & consolidate protocols	CCE	Progress

Notes:
Discussion underway to develop easy-to-use protocol cards on various topics. NCHE will contact national Health Education Specialist to obtain inventory of materials available.

CCLLR 3: Improved sustainability of MCHN services

Indicator	**Measurement Method and Frequency**	**Targets**	**This Quarter**
% *project** resources leveraged by partners for MCH/N service delivery or program design	Match tracking reports; quarterly	50%	19%

*changed from DIP

Activities crosscut through the tables above.

Notes: Match tracking reporting divided, with each technical program officer collecting data on match. DHMT and MSF have had a greater contribution towards match this quarter through training of Counselors (MSF), provision of transport for Home based care visitations (MSF), procurement of equipment (BP Machines, thermometers) for RHCs, and water transport safety accessories (DHMT), Orientation of Community Health Workers in Malaria treatment protocols (DHMT). During this quarter, partners contributed $11,698 (approximately 19%) of project costs. This figure will increase in the following weeks as additional resources not acknowledged on the last match report are counted.

Annex A-2

Report on Annual Indicators
From NCHE's Monitoring Plan

The following indicators from NCHE's monitoring plan are reported on an annual basis.

LLR1.1: Increased availability of MCHN Services

Indicator	**Measurement Method**	**Target**	**Status**
# CBAs operating	DHIS	TBD by each RHC staff	35%

Notes: Calculated from HMIS data, though scanty at this point.

LLR1.2: Enhanced quality of MCHN service delivery

Indicator	**Measurement Method**	**Target**	**Status**
% communities or **catchment areas** with active NHCs	DHIS	90%	90%
% communities monitoring MCH data	DHIS	70%	Not measured

Notes: While there is 100% NHC presence in the district, one catchment area has been inactive for the past six months. All communities are monitoring MCH data through CHWs and TBAs, but the way this is done is being reviewed for improvement.

LLR1.3: Improved advocacy and coordination of MCHN services

Indicator	**Measurement Method**	**Target**	**Status**
# intersectoral meetings taking place	Meeting minutes	4	100%

Notes: All planned intersectoral quarterly meetings were convened, including Epidemic Preparedness Committee, Tender Board Committee and District Health Board.

LLR2.1: Increased demand for and utilization of MCHN servies

Indicator	**Measurement Method**	**Target**	**Status**
% population using MCHN services at health facility	DHIS	80%	72%
% population using MCHN community-based services	DHIS	80%	13%

Notes: Data used from GMP/N, ANC, deliveries and PNC coverage data submitted by RHCs. Note that community-based service use may be higher because some RHCs did not submit data. Most communities access MCHN services in their communities through static and outreach clinics.

LLR2.2: Increased access to MCHN services

Indicator	**Measurement Method**	**Target**	**Status**
% communities with emergency referral plan	DHIS	80%	15.7%

Notes: Some communities in one catchment area have a plan for delivering an emergencey obstetric case at referral.

LLR2.3: Improved knowledge of prevention and care-giving practices and improved care-seeking behaviors

Measured at baseline and end of project.

CCLLR1: Improved integration and coordination within formal health sector and between formal health sector and community

See LLR1.3 for indicators.

Notes: DHMT, RHCs and community are working together during the planning, implementation and monitoring of jointly-designed workplans.

CCLLR2: Enhanced organizational development and capacity of DHMT, DTF, and PCI

Indicators	**Partner**	**Target**	**Status**
Hold HIV/AIDS fairs	DTF	Bi-annually	Currently, just one event annually on World AIDS Day
Information dissemination -data collection & aggregation -analysis -report writing -hold intersectoral mtgs	DHMT	Bi-annually	Progress – held 75% of planned intersectoral meetings of past year
Performance analysis (SWOT)	DTF	Bi-annual	Currently, one conducted at end of each calendar year
Conduct BEACON	DTF	Annually	Qualitative assessment conducted
I-STAR Assessment	DHMT	Annually	Need training
Trainings (NHC, HC, DHMT) 1-identify trainers 2-identify & select trainees 3-module preparation 4-arrange trainings (venue, accommodation, transport, food, etc.)	DHMT	Annually	Progress in cataloguing NHC schedules and RHC meetings; identified training needs with ROSA and DIP workshop; host quarterly technical updates for RHC staff
Participatory planning 1-Problem identification	DHMT	Annually	Progress – all RHC plans started from community level through NHCs to

2-Prioritization 3-Analysis 4-Action Planning			HCC
1-Write annual work plans 2-Conduct self assessment 3-Write institutional workplans	DTF	Annually	Progress – began work plans

CCLLR3: Improved sustainability of MCHN services

Indicator	**Measurement Method**	**Target**	**Status**
% project activities undertaken by partners (using own resources)	Project HIS; match tracking reports	80%	18%

Notes: "Own" resources difficult to ascertain for DHMT, as financial resources flowing through government channels are mainly donor funds. DTF has met during the planned executive and general membership meetings within its resource limits. Partners matched NCHE with $45,000 this year, or more than 18% of direct program costs. This figure will increase in the following weeks as additional resources not acknowledged on the last match report are counted.

Year 2 NCHE Workplan

Activities Beginning Quarter 1

Activity	**Lead Coordinator***
Review DHMT quarterly monitoring data (for 3rd quarter) and participate in meeting	Advisor, Manager
Facilitate proposal-writing with NHCs to ZAMSIF to construct housing for RHC staff	Project Manager
Revitalize NHCs; create more outreach points; acquire, adapt and distribute health education materials to RHCs and outreach posts	Outreach Coordinators, Advisor
Train existing CHWs in C-IMCI; Train and support more CHWs	Training and Outreach C.s
Strengthen counseling (review and update protocols in all service areas and increase supervision of this)	VCT Coordinator
Train/refresh RHC and DHMT staff in IMCI, modern contraceptive technology, STI management, and PAC	Training Coordinator
Solicit and incorporate feedback from RHC staff regarding supervision and motivation programs	Training Coordinator
Review and adapt TBA training materials	Advisor, Outreach and Training Coordinators
Review and update protocol regarding staff accompanying referral cases	Manager, DHMT
Review and update ANC protocol	Advisor, Training Coordinator
Stakeholders in Health Meeting (SHIHM - October)	Manager
SHIHM (November)	Advisor
SHIHM (December)	Manager

Quarter 2

Train and support more TBAs	Training Coordinator, Advisor
Test water supply at RHCs and communal water points	Training Coordinator, DHMT
Improve record keeping (review/update forms, review proper record keeping with staff, increase supervision of this)	Advisor, DHMT
Operations research to reduce HIV/AIDS stigma	Advisor, Manager
Review DHMT quarterly monitoring data and participate in quarterly meeting	Advisor, Manager
SHIHM (January)	Training Coordinator
SHIHM (February)	Advisor
SHIHM (March)	Manager

Quarter 3

Review and revise schedule of services with community feedback (increase frequency of static sessions)	Outreach Coordinators
Assess conditions and resources, and create and implement community-based monitoring of MCH	Outreach Coordinators, Advisor
Canvas community regarding perceived quality of services, preferred service schedules, and contraceptive preference	Outreach Coordinators, Manager
Create motivation and support plan for TBAs with communities	Outreach Coordinators, Advisor
Review and update TBA supervision plan	Training Coordinator, DHMT
Review and update client evaluation plans for RHC and community-based services	Training Coordinator, DHMT
Review and update motivation plan for RHC staff	Training Coordinator, DHMT
Educate community regarding appropriate care-seeking behavior and recognition of danger signs with mass and small media, by deploying more trained CBAs and equipping more outreach posts	Outreach Coordinators
Create or adapt and field test mass and small media to educate community regarding services available, and when to seek care	Outreach, VCT Coordinators
Schedule quarterly "Health Chats" between RHCs and NHCs	Outreach Coordinators
Organize role plays with NHCs to illustrate causes of childhood illness, danger sign recognition of child and maternal illness, and appropriate care-seeking behavior. Role plays will also be used to facilitate discussion about HIV/AIDS issues.	Outreach and VCT Coordinators
Work with NHCs to organize events that demonstrate behaviors of positive deviants	Outreach Coordinators
Strengthen breastfeeding promotion groups (BPG) and establish where they do not exist	Outreach C.s
Hold "Breastfeeding Fairs" with positive deviants every six months, organized by NHCs	Outreach C.s
Using HEARTH model, organize community demonstrations with positive deviants and NHCs	Outreach C.s
SHIHM (April)	Training Coordinator
SHIHM (May)	Advisor
SHIHM (June)	Manager

Quarter 4

Establish or upgrade "rooming in" program for mothers delivering in RHCs	Training Coordinator, Manager
Educate RHC staff regarding community behaviors and encourage them to promote messages using mass and small media	Outreach and VCT Coordinators
Train DHMT in principles of supportive, dialogue-based supervision and appreciative inquiry	Training Coordinator, Manager
Review and revise supervision plan (update checklists, vary schedule, including surprise visits, increase supervision in certain areas like counseling and contraceptive distribution	Training Coordinator, Manager
Increase/improve supervision of CBAs	Outreach Coordinators
Coordinate regular intersectoral meetings	Training Coordinator
Establish/revitalize community-based GMP (train CBGMPs, link with NHCs, and ensure feedback of data to RHCs)	Outreach Coordinators
Advertise increased service, provider, and product availability and improved quality of services (using criteria identified by community) through mass and small group media and through CBAs	Manager, Advisor
SHIHM (July)	Training Coordinator
SHIHM (August)	Manager
SHIHM (September)	Training Coordinator

**To begin, Lead Coordinators should notify/invite counterparts from DHMT and DTF and other participating staff from PCI regarding activity and develop plans with partners to accomplish assigned tasks, then review plans with NCHE Project team and adapt based on feedback.*

Note: Project team meetings occur every Monday.

Capacity Building Plan, Year 2

Standard: We share widely and discuss evaluation findings with network members.

Activity	Key People	Schedule
DTF		
Annual General Meeting	PCI Field coor. DTF Exec.	Quarterly & Annually
Quarterly Meeting (Field Office) 1-Arrange mtgs 2-Review previous annual workplans 3-Develop uniform reporting format 4-Discuss achievements & areas to improve 5-Discuss solutions 6-Draft annual workplans	All	Quarterly
Hold HIV/AIDS fairs	All	Bi-annually
DHMT		
Information dissemination -data collection & aggregation -analysis -report writing -hold intersectoral mtgs	HIO DDH	Bi-annually
Attend intersectoral meeting (7 districts) -prepare reports (district level, RHC level, commty level)	DDH, MP, HIO	Quarterly

Standard: We engage in systematic, regularly scheduled self-assessments of organizational capacity

Activity	Key People	Schedule
DTF		
Qtrly & Annual Meetings 1-report on activities from institutions 2-Identify gaps	Exec. Committee (coordinate DTF activities	Monthly, Quarterly, Annually

3-Identify solutions to gaps 4-Develop action plans		
Performance analysis (SWOT)	Same as above	Bi-annual
Conduct BEACON	Same as above	Annual
DHMT		
Performance Assessment/QA 1-Prepare PA tools 2-Distribute PA tools 3-Give specific feedback to HC 4-Give feedback to all facilities	DDH	Quarterly
Self Assessment 1-Distribute data collection tools 2-Collection of data & aggregation 3-Data validation 4-Data analysis 5-Feedback to specific indicators 6-Feedback to all facilities	MP	Quarterly
Action & workplan review 1-Prepare reports 2-Hold intersectoral mtgs	DDH	Quarterly
I-STAR Assessment	All	Annually

Standard: Problem solving and decision-making are done collaboratively between line staff and supervisors.

Activity	Key People	Schedule
DTF		
Holding inter-& multi-sectoral meetings/prgs 1-Identify institution w/ common interests 2-Define operational grounds 3-Draw up objectives 4-Support visits 5-Explore use of Apprec. Inquiry approach	DTF membership Chairman Role: coordinating mtgs Exec. members DTF Exec. Members DTF	Monthly Quarterly When necessary 2nd quarter 2nd quarter
DHMT		
Trainings (NHC, HC, DHMT)	MP	Annually

1-identify trainers 2-identify & select trainees 3-module preparation 4-arrange trainings (venue, accommodation, transport, food, etc.)		
Meetings (CBHM, Technical) 1-prepare agenda 2-make appointments 3-select venue	MP	Monthly
Support supervision	MP	Monthly, Quarterly

Standard: Client needs and opinions are considered to be important dimensions of quality

Activity	Key People	Schedule
DTF		
1-Conduct needs assessment 2-Advocate rights of client 3-Counseling (data) 4-Follow-up assessment mtgs 5-Coming up w/ basic questions during counseling	DTF/Chairman PCI Field Coordinator Roles: Advocacy Awareness Sensitization	On-going
DHMT		
A-Exit survey interviews 1-prepare checklists 2-distribute to interviewers/supervisors 3-identify clients 4-feedback to service providers/community	MP, I/C's	Quarterly
B-Participatory planning 1-Problem identification 2-Prioritization 3-Analysis 4-Action Planning	MP, I/Cs	Annually

Standard: We access and apply relevant technical information to program design work

Activity	Key People	Schedule

DTF		
1-Write annual work plans 2-Conduct self assessment 3-Write institutional workplans	Entire DTF/Chairman Roles: integrate all workplans submitted	Annually
DHMT		
Training specific (PLA, Log/Results Framework) 1-Identify trainers/trainees 2-Module prep. 3-Arrange for trainings	MP, NE, HIO	Sept-Dec. '03
Literature review 1-Procure available relevant literature	MP, CCE, HIO	Quarterly
Consultative mtgs 1-Schedule appts	DDH	Oct-Dec. '03
Study Tour 1-Arrange trips 2-Consultative talks	MP	April- June '04
Internet connection	MA	Jan- March '04
Write annual work plans		Annually

Standard: We work to de-stigmatize HIV/AIDS

Activity	Key People	Schedule
DTF		
Decentralize VCT 1-counseling 2-procure logistics (test kits)	DTF/chairman Role: to coordinate & mitigate	On-going
Revamp & Form new anti-AIDS clubs 1-community sensitization 2-recruit members 3-train & assign roles	Same as above	On-going
Form post-test clubs 1-community sensitization 2-recruit members 3-train & assign roles	Same as above	On-going

DHMT		
IEC/BCC 1-Procurement of IEC materials 2-distribute materials 3-train counselors & peer educators	CCE	June 03-June 06
Training of health workers See 3 a, b, c & d	MP	Sept-Oct 03
Monitoring of counseling services. 1-develop plan 2-tools	HIO	July 03

Standard: We address nutritional needs of PLWHAs

Activity	Key People	Schedule
DTF		
Design nutritional programmes for homecare teams 1-Introduce nutritional lessons 2-identify individuals/ families for nutritional lessons	Nutritional Expert/DTF Roles: Responsible for nutritional trainings and advocate for supplementary feedings	Jan-Dec. 2004
Solicit for supplementary foods		Jan-Dec. 2004
DHMT		
Adapt existing manuels to Zambian (Nchelenge) context 1-procure/acquire nutritional manuels on HIV/AIDS (Zimbabwe, FAO, & RSA 2-hold technical meetings/workshop 3-manuel development 4-demonstration contests 5-distribute adapted manuals	NE	June- July 2003
Monitoring harmonize w/ PSG, MSF 1-home-based care (visits)register 2-identify PLWHAs	CCE	June '03 on
Promotion of Agro-production of nutritious foods 1-identify foods 2-seed multiplication 3-production 4-demonstration on utilization	NE	Jan. '04
Counseling in Nutrition (TIPS)	NE	June-on

Service delivery protocols exist and are regularly revised and updated (DHMT only)

Activity	Key People	Schedule
Review existing protocols 1-check correctness & completeness 2-formulate tech. Committees 3-feedback- Qtrly mtgs 4-write & consolidate protocols	CCE	Oct-Dec. 2003
Formulate new protocols 1-consultations (local & natl) data collection, analysis, validation 2-feedback 3-disseminate/distribute new protocols 4-train in new protocols	CCE	Jan-Mar. '04

Annex B-2

NCHE WORK PLAN: Q 1, Y 2 (October - December)

Activity	**Lead Coordinator***	**Start Time**
Continue clinical reviews	Training Coordinator	ongoing
Create and implement maintenance schedule for RHC and hospital equipment	Manager	ongoing
Adapt tools and assess hospital facility and services	Manager, Training Coordinator	October
Procure and deliver drugs, vaccines, supplies, and other equipment to RHCs	Manager, OC (Melina)	ongoing
Expand coverage of Chlorin social marketing campaign (with SFH)	Advisor	October
Conduct further research on care-seeking behaviors (doer/non-doer analysis)	Manager	ongoing
Qualitative Research training	Manager	October
Decentralize VCT *[unpacked]***	Advisor, VCT Coordinator	ongoing
Review DHMT quarterly monitoring data (for 3rd quarter) and participate in meeting	Advisor, Manager	October
Revitalize NHCs; create more outreach points; acquire, adapt and distribute health education materials to RHCs and outreach posts; assist communities with Zamsif proposals *[unpacked]***	Outreach and VCT Coordinators, Advisor	Ongoing
Train existing CHWs in C-IMCI; Train and support more CHWs	Training and Outreach C.s	October
Strengthen counseling (review and update protocols in all service areas and increase supervision of this) *[unpacked]***	VCT Coordinator	October
Train/refresh RHC and DHMT staff in IMCI, modern contraceptive technology, STI management, and PAC *[unpacked]***	Training Coordinator	October
Solicit and incorporate feedback from RHC staff regarding supervision and motivation programs	Training and Outreach Coordinators	October
Review and adapt TBA training materials	Advisor; Outreach and Training Coordinators	October
Review and update protocol regarding staff accompanying referral cases	Manager; DHMT	October
Review and update ANC protocol	Advisor; Training and Outreach Coordinators	October
Conduct PMTCT FGDs	Advisor, Outreach C.s	October
SHIHM (October)	Manager	October
SHIHM (November)	Advisor	November
SHIHM (December)	Manager	December

**To begin, Lead Coordinators should notify/invite counterparts from DHMT and DTF and other participating staff from PCI regarding activity and develop plans with partners to accomplish assigned tasks, then review plans with NCHE Project team and adapt based on feedback.*

***Refer to "unpacked" timetable*

Note: Project team meetings occur every Monday.

Annex B-3

UNPACKED TIMETABLE
25 September 2003
initials indicate assignment

Decentralize VCT

1. Training for VCT counselors (RHC staff—need 2); locate training outside of district and send staff. Need XX more community counselors. DT
2. Supplies: order now for Kanyembo and Kashikishi. MM
3. Training for reading tests (laboratory). Arrange with lab staff at hospital. DM *on hold until supplies are in.*
4. Infrastructure: need 4 small tables and 8 chairs for counseling rooms at RHCs. DT to find in PCI budget.
5. Awareness campaign (link now with revitalizing NHCs). Need literature and leaflets about VCT in Bemba. JY to check with Health Promotion Specialists at CBOH, ZIHP, SFH, and Sue at MSF. Organize dramas and a pre-community visit meeting with DTF. Need fuel and fees for drama groups. BC, MM, CM
6. Post-test clubs. Link with Mbereshi and Dan Church Aid now. BC
7. Mobile VCT teams. TBD after other steps underway.

Revitalization of NHCs

1. Taking inventory of NHCs at 10 RHCs; dates for meetings; determine number of zones in each RHC. BC (partially completed).
2. Which NHCs need training? Does NHC membership represents all zones? Is there a need for Village Health Committees in some areas? Check with MPD regarding how things are going now and how to identify unrepresented areas. MM/DM
3. Orientation meetings/"quiet" needs assessment, including community contributions. Take video to NHC meetings. OCs and VC. JY to look for donation of 10 short-wave radios.
4. Begin PLA; choose emphasis behaviors; acquire, adapt and distribute corresponding IEC materials. Create outreach points with communities. Assist community re Zamsif proposals (DT to work with MPD). JY to give report from Indonesia. CM and DT begin Q2 and work with ZIHP (Moses Zulu).

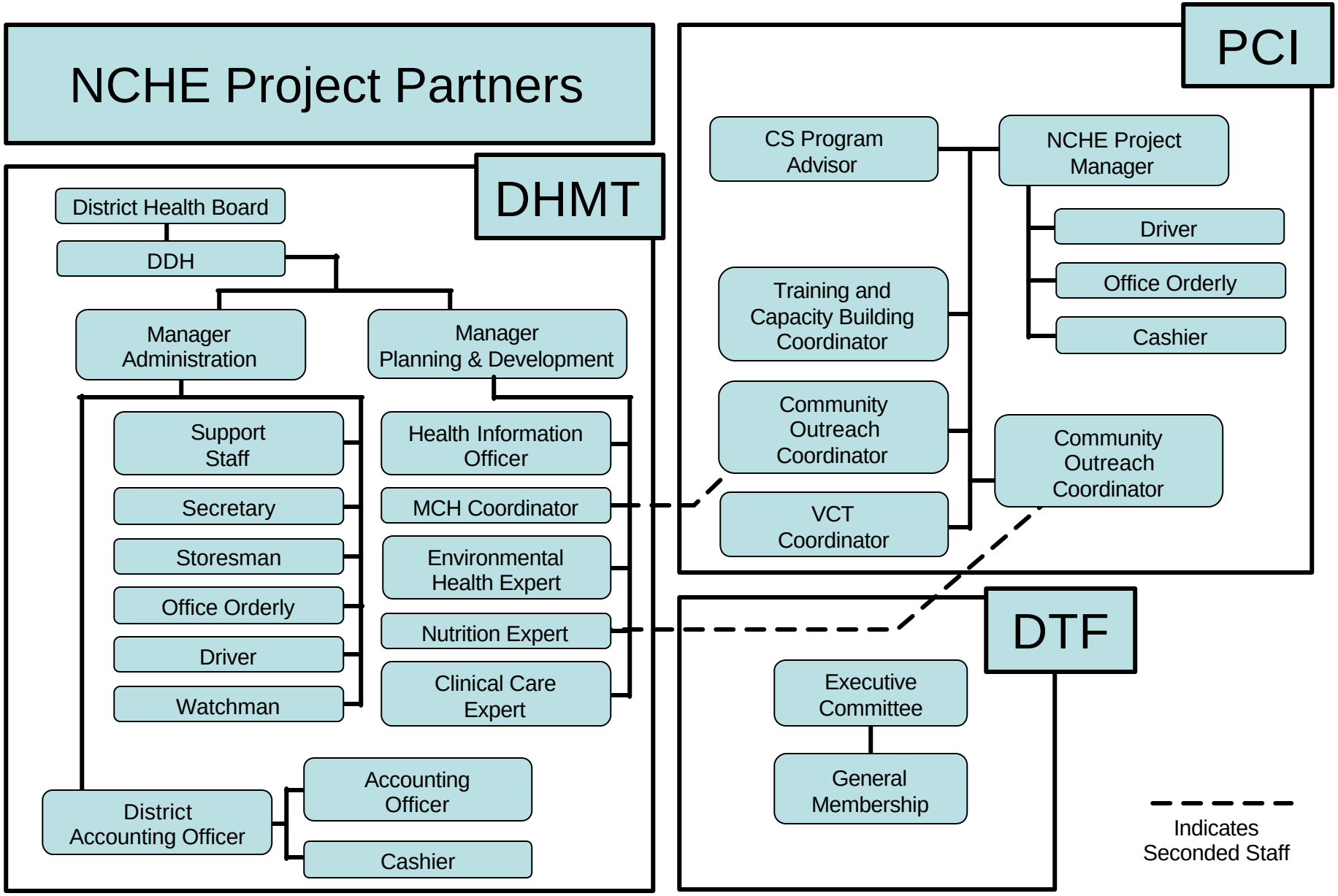
Strengthening Counseling

1. Create inventory of counselors (facility-based). BC, CM, MM
2. Increase supervision of IMCI and use of counseling cards quarterly. Also follow up use of family planning counseling kits (MPD, DT, DM)

3. Quarterly meeting- put counseling on agenda. Discuss what areas of counseling are currently provided and what areas are lacking (for adults; other than HIV). Suspect STI counseling given evidence from HFA. MPD, DT, DM
4. Depending on recommendations from quarterly meeting, organize creation and lamination of counseling cards in identified areas. (DT, DM)
5. Staffing: advocate with local MP in Nchelenge and Lusaka. Zamsif proposals (with NHCs, above).
6. Clinical reviews are another opportunity to reinforce counseling skills. DM

Train/refresh RHC and DHMT staff

1. IMCI: for 2 weeks at end of ICT training in December. DT to give JY number of staff to attend.
2. STI: at a quarterly meeting. MM/DM
3. Modern contraceptive technology: check with Mansa then with CBOH regarding sentinel sites. Propose to decentralize to hospitals. Also check with Mansa regarding ICT. JY
4. PAC: same as #3. JY


NCHE Project Partners
DHMT
District Health Board
DDH
Manager Administration
Manager Planning & Development
Support Staff
Secretary
Storesman
Office Orderly
Driver
Watchman
Health Information Officer
MCH Coordinator
Environmental Health Expert
Nutrition Expert
Clinical Care Expert
District Accounting Officer
Accounting Officer
Cashier
PCI
CS Program Advisor
NCHE Project Manager
Driver
Office Orderly
Cashier
Training and Capacity Building Coordinator
Community Outreach Coordinator
VCT Coordinator
Community Outreach Coordinator
DTF
Executive Committee
General Membership
Indicates Seconded Staff